New Jersey Occupational Therapy Advisory Council
CHECK LIST

A T T E N T I O N

PLEASE NOTE: *The Applicant Is Responsible For Carefuly Reading Instructions And Rules And Regulations Before Submitting An Application For Licensure.* ***PLEASE DO NOT SUBMIT THIS PAGE***

Before completing your application, please be sure that the following documentation is submitted contemporary to application. ***Incomplete applications will not be considered until all documentation is received by the council.***

- ❑ **Letter Of Instructions**
- ❑ **Certification And Authorization Form For A Criminal History Background Check.** *(If This Is Your Initial Application For Licensure Do Not Send Fee Until You Are In Receipt Of A Notification From The Council).*
- ❑ **Statutes And Regulations** (http:www.njconsumeraffairs.gov/occup/regstat.pdf)
- ❑ **Application** *(Pages 9 To 14)*
- ❑ **Photograph Placement Sample** *(Do Not Submit With Application)*
- ❑ **Three Verification Of State License Forms** *(Print As Many As You Need)*
- ❑ **Two (2) Certificates Of Good Moral Character**
- ❑ **Initial Verification Of Supervision Forms**
  (For Temporary License Applicants Only)
- ❑ **Final Verification Of Supervision Forms**
  (For Temporary License Applicants Only)

JON S. CORZINE
Governor

New Jersey Office of the Attorney General

Division of Consumer Affairs
Occupational Therapy Advisory Council
124 Halsey Street, 6th Floor, Newark, NJ 07102

ZULIMA V. FARBER
Attorney General

STEPHEN B. NOLAN
Acting Director

Mailing Address:
P.O. Box 45037
Newark, NJ 07101
(973) 504-6570

PLEASE KEEP THIS LETTER OF INSTRUCTIONS FOR FUTURE REFERENCE

******YOU MAY NOT PRACTICE OCCUPATIONAL THERAPY IN THE STATE OF NEW JERSEY UNTIL YOU ARE IN POSSESSION OF YOUR TEMPORARY LICENSE (UNDER SUPERVISION ONLY) AND/OR PERMANENT LICENSE REGISTRATION CERTIFICATE******

Dear Applicant:

Please read all instructions, Statutes, Regulations governing the practice of Occupational Therapy and the additional forms provided, before completing the application. Your answers must be accurate and relevant to the type of license you are requesting. Upon receipt of your application and fee, you will be sent a post card/acknowledgment receipt of the application and further information.

Applications will not be presented to the Council for consideration of licensure until the application is complete with all supporting documentation and the appropriate fee. Applications will be reviewed in date order received. You must notify the Council office ***immediately*** of any changes, such as your address, employment, licensure status in another state and/or changes to a response given in your application.

"MAKE SURE YOU MEET REQUIREMENTS FOR LICENSURE BEFORE SUBMITTING YOUR APPLICATION"

INTERNATIONALLY EDUCATED APPLICANT MUST SUBMIT AN OFFICIAL TRANSLATION OF THEIR DOCUMENTATION.

Note: This application will not be considered until the following documents and fees have been received:

* One signed, passport-type photograph certified by a notary public and attached to application. **See sample** ***(Photograph must be attached to application not to sample page)***

* The non-refundable application fee of $100.00 by check or money order payable to: "State of N.J. Occupational Therapy Advisory Council" must accompany your application. **Applications without the appropriate fee will not be processed.**

Application Instructions Continued

- Certification and Authorization Form for a Criminal History Background Check. Form must be submitted complete, signed and certified. If you answer "No" to question # 5 of this form, **DO NOT** submit a fee at this time. Further instructions will follow

TRANSCRIPTS*:* ***(Transcripts shall be forwarded to the Council directly by the College or University-OT Dept).***

- ***OCCUPATIONAL THERAPISTS:*** *An official transcript of your professional education, with a B.S. in Occupational Therapy ("O.T".) or a B.S. and certification in O.T.*

* ***OCCUPATIONAL THERAPY ASSISTANTS:*** *An official transcript of your professional education, with an Associates Degree in O.T. or an Associates Degree and a certification in O.T.*

* ***Field Work Experience: (must be forwarded directly by the College or University from their OT Department directly to the Council)***

Documentation indicating that the applicant has successfully completed at least ***24 weeks*** *of supervised field work experience for occupational therapists* ***(OT)****; and* ***12 weeks*** *for occupational therapy assistants (OTA).*

*This documentation must contain the name , address and telephone number of the institution where the fieldwork was completed; the dates (days, months and years); the number of hours per week; the name of the supervisor****.***

- ***NATIONAL BOARD FOR CERITIFICATION IN OCCUPATIONAL THERAPY ("NBCOT")***

For applicants who have taken the certification examination ***prior to January 1, 2003****, a* ***"Verification of Certification"*** *letter from the National Board for Certification in Occupational Therapy* ***("NBCOT").*** *For applicants who have been taken the certification examination on or* ***after January 1, 2003,*** *a score transfer from NBCOT indicating the passing of the certification examination..* ***Certification and/or Scores Transfer shall be forwarded to the Council directly by NBCOT.***

TEMPORARY LICENSES ONLY

- *Applicants for Temporary Licenses must submit* ***"Confirmation of Examination Registration and Eligibility to Examine "*** *letter to be forwarded directly from* ***NBCOT.***

- *Applicants must indicate in writing the precise month, day and year of the* ***NBCOT*** *examination that will be taking.*

- *Two completed Certificates of Good Moral Character.*

Application Instructions Continued

- ***Verification of supervision form*** *to be completed by the applicant and the O.T. supervisor(s) at each "future" place of employment and submitted along with a $50.00 check or money order payable to : "Occupational Therapy Advisor Council".* ***FUTURE STARTING DATE OF SUPERVISION MUST BE PRINTED ON THE INITIAL FORM.*** *This is a future date and may be at least 5 to 7 days* ***after*** *the Temporary License fee and supervision form is received by the Council. Please allow enough mailing time.*

  <u>Do Not submit this form until you receive notification from the Council that your application is complete.</u>

- **"Name Change"** If your name has been changed due to Marriage, Divorce or any other legal procedure, or if a different name may appear on documents submitted as part of the application, you must provide the appropriate documentation. You ***must*** submit the original or a notarized "true copy" of the document.

  "Other state license" Three (3) **"Verification of State License"** forms are provided to be completed by you and the state in which you currently hold and/or held any professional or occupational license. (Additional forms may be requested)

INTERNATIONALLY LICENSED APPLICANTS MUST SUBMIT AN OFFICIAL VERIFICATION OF THEIR LICENSES DIRECTLY FROM THE LICENSING COUNTRY ATTACHED TO AN OFFICIAL TRANSLATION.

Upon approval of your application for licensure, you will receive notification to forward a separate payment of your biennial licensing fee. **Please refer to the enclosed regulation: <u>N.J.A.C.</u> 13:44K-11.1 Fee Schedule.**
Do not send the licensing or any other fee at this time. Send only the application fee of $ 100.00.

APPLICATIONS WILL NOT BE CONSIDERED UNTIL ALL ORIGINAL DOCUMENTATION AND APPROPRIATE FEE HAS BEEN RECEIVED BY THE COUNCIL OFFICE.

Enclose fee along with the application and mail to:

New Jersey Office of the Attorney General
Division of Consumer Affairs
Occupational Therapy Advisory Council
P.O. Box 45037
Newark, NJ 07101

Note: ***Please allow 6 to 8 weeks for processing***. An incomplete application will not be processed until all required fees and ***original*** documents are received.

<u>" FROM TEMPORARY STATUS TO PERMANENT LICENSE "</u>

If you hold a Temporary License and had passed the NBCOT examination, you are now eligible to request a change of status by sending a letter to the Council. The letter addressed to the Council with the change of status request should have the name and address s of the place (s) of employment and the name of your direct supervisor (s) at each place of employment if applicable.

Pursuant to N.J.S.A. 45:9-37.67 A holder of a Temporary license may continue to practice Occupational Therapy in New Jersey only under the direct supervision of a licensed Occupational Therapist until its expiration and/or in possession of a Permanent License Registration Certificate.

If you need further assistance, please do not hesitate to contact the Council office at the above mailing address.

THE ENCLOSED APPLICATION IS SUBJECT TO CHANGE WITHOUT PREVIOUS NOTIFICATION

JON S. CORZINE
Governor

New Jersey Office of the Attorney General
DIVISION OF CONSUMER AFFAIRS
Occupational Therapy Advisory Council
124 Halsey Street, 6th Floor, Newark, NJ 07102

ZULIMA V. FARBER
Attorney General

Stephen B. Nolan
Acting Director

Mailing Address:

P.O. Box 45037
Newark, NJ 07101
(973) 504-6570

To All Applicants:

If You Have Answered **"No"** To Question # 5

Of

***The Certification And Authorization For Criminal History background Form*,**

PLEASE: ***Do Not*** Submit Fee At This Time.

Official Use Only

Dual License

☐ License Type 1

_____

Applicant's Number

_____

License Type 2

_____

Applicant's Number

_____

Official Use Only

Resubmit

☐

Board or Committee

_____

New Jersey Office of the Attorney General

Division of Consumer Affairs
Occupational Therapy Advisory Council
P.O. Box 45037
Newark, New Jersey 07101
(973) 504-6570

CERTIFICATION AND AUTHORIZATION FORM FOR A CRIMINAL HISTORY BACKGROUND CHECK

Directions: Answer all of the questions on this form.

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
   Last First Middle Maiden Name

2. Address _____
   Street or P.O. Box City State ZIP code

3. Date of birth __ __ /__ __ /__ __ Sex: ☐ Male ☐ Female
   Month Day Year

4. Social Security number _____ /_____ / _____

5. Have you completed the fingerprinting process for any **Board or Committee of the New Jersey Division of Consumer Affairs** since November 2003? ☐ Yes ☐ No
   If "No," you will receive a separate mailing from the Board or Committee regarding the criminal history background process. Please send no payment now.
   If "Yes," please provide the following information and follow the instructions outlined below:

   _____ _____
   Board or committee requiring the fingerprinting Month and year you were fingerprinted

   If you were fingerprinted after November 2003 as part of the criminal history background process for licensure or certification by any other **Board or Committee of the New Jersey Division of Consumer Affairs**, you will not be required to be fingerprinted a second time. However, the Division must perform a criminal history background check each time you apply for licensure or certification. The fee for this background check will be $33.00. Payment should be made in the form of a check or money order payable to the State of New Jersey and should accompany your application packet.

6. Have you ever been arrested and/or convicted of a crime or offense? (Minor traffic offenses such as a parking or speeding violations need not be listed.) ☐ Yes ☐ No

   Every such conviction on record must be disclosed. A true copy of every police report, judgment of conviction, sentencing order and termination of probation order, if applicable, **must** be submitted with this form. Any documents (including employer or supervisor letters of reference, if applicable) which present clear and convincing evidence of rehabilitation **must** be submitted with this form. **Failure to follow these instructions may result in the denial of an initial application.**

   Note: Copies of judgments, sentencing and termination of probation orders may be obtained from the clerk of the county where those orders, disposing of the conviction, were issued and filed.

   Your continuing responsibility to disclose convictions of crimes or offenses: You **must** notify the Board or Committee within five (5) business days if you are convicted of any crimes or offenses after this form has been completed.

CERTIFICATION

I, _____ , in making this application to the Board or Committee for certification or licensure, certify that I am the applicant and that all of the information provided in connection with this application is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny certification or licensure or to withhold renewal of or suspend or revoke a certificate or license issued by the Board or Committee.

I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for certification or licensure. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Board or Committee.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

_____ _____

Signature of applicant Date

Attach a clear, full-face passport-style photograph (2"x2") of your head and shoulders, taken within the past six months.

A photo is required with each application.

Do not use staples to attach the photograph.

Polaroid or digital photographs are not acceptable.

For office use only

New Jersey Office of the Attorney General
Division of Consumer Affairs
Occupational Therapy Advisory Council
124 Halsey Street, 6th floor, P.O. Box 45037
Newark, New Jersey 07101
(973) 504-6570

Application for Licensure

Date _____ Date of birth: _____

Check one:

- ☐ Occupational Therapy
- ☐ Occupational Therapy Assistant

Check appropriate category:

- ☐ License
- ☐ Temporary License

A nonrefundable application filing fee of $100 in the form of a check or money order made out to the State of New Jersey, must be submitted with this application for licensure or certification. (Applicants should understand that if the application filing fee is paid with a personal check, and the check is returned by the bank due to insufficient funds, the next step in the licensure or certification process will be delayed until the fee is paid.)

The Council maintains, as part of its responsibilities, a record of your home address, business address and mailing address. You may choose which of these addresses will be considered as your "address of record." If you do not indicate (by putting a check in the appropriate box) which address should be used as your address of record, your mailing address will be considered to be your address of record. A post office box may be used as your address of record, but only if you provide another address which includes a street, city, state and ZIP code.

Information that you provide on this application may be subject to public disclosure as required by the Open Public Records Act (OPRA).

Please print clearly. You must answer all of the questions on this application.

Personal Information

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
   Last name | First name | Middle initial | Maiden name

2. Address

   ☐ Home: _____
   Street or P.O. Box | City | State | ZIP code | County

   _____ _____
   Telephone number (include area code) | E-mail address

   ☐ Business: _____
   Name of company | Telephone number (include area code)

   _____
   Street | City | State | ZIP code | County

   ☐ Mailing: _____
   Street or P.O. Box | City | State | ZIP code | County

3. Social Security Number

You **must** disclose your Social Security number for the reasons stated below. Failure to do so may result in a denial of licensure or certification or license or certificate renewal.

*Social Security Number: _____- _____ - _____

*Pursuant to N.J.S.A. 54:50-24 et seq. of the New Jersey taxation law, N.J.S.A. 2A:17-56.44e of the New Jersey Child Support Enforcement Law, Section 1128E(b)(2)A of the Social Security Act and 45 C.F.R. 60.7, 60.8 and 60.9, the Board is required to obtain your Social Security number. Pursuant to these authorities, the Board is also obligated to provide your Social Security number to:

a. the Director of Taxation to assist in the administration and enforcement of any tax law, including for the purpose of reviewing compliance with State tax law and updating and correcting tax records;

b. the Probation Division or any other agency responsible for child support enforcement, upon request; and

c. the National Practitioner Data Bank and the H.I.P. Data Bank, when reporting adverse actions relating to health care professionals.

4. Citizenship / Immigration Status

Federal law limits the issuance or renewal of professional or occupational licenses or certificates to U.S. citizens or qualified aliens. To comply with this federal law, check the appropriate box below which indicates your citizenship/immigration status. If you are not a U.S. citizen, attach a copy of your alien registration card (front and back) or other documentation issued by the office of U.S. Citizenship and Immigration Services (USCIS).

☐ U.S. citizen
☐ Alien lawfully admitted for permanent residence in U.S.
☐ Other immigration status

Questions about your immigration status and whether or not it is a qualifying status under federal law should be directed to the USCIS at: 1-800-375-5283.

5. Student Loan

Are you in default in regard to any student loan obligation(s)? ☐ Yes ☐ No

If "Yes," you must obtain documentary evidence that you have reached an arrangement with the bank or with the entity that issued your student loan, for the eventual repayment of the loan. You will not be able to obtain a license or certificate unless you provide the required documents concerning the plan for repayment of your student loan.

6. Child Support

Please certify, under penalty of perjury, the following:

a. Do you currently have a child-support obligation? ☐ Yes ☐ No

(1) If "Yes," are you in arrears in payment of said obligation? ☐ Yes ☐ No

(2) If "Yes," does the arrearage match or exceed the total amount payable for the past six months? ☐ Yes ☐ No

b. Have you failed to provide any court-ordered health insurance coverage during the past six months? ☐ Yes ☐ No

c. Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding? ☐ Yes ☐ No

d. Are you the subject of a child-support-related arrest warrant? ☐ Yes ☐ No

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "Yes" to any of the questions a(1) through d will result in a denial of licensure or certification. Furthermore, any false certification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure or certification.

_____ _____ _____

Applicant's name (please print) Applicant's signature Date

7. Medical Conditions Questions

Questions a through f pertain to medical conditions and use of chemical substances. Please read the definitions carefully. Your responses will be treated confidentially and retained separately. Please be aware that you have the right to elect not to answer those portions of the following questions which inquire as to the illegal use of controlled dangerous substances or activity if you have reasonable cause to believe that answering may expose you to the possibility of criminal prosecution. In that event, you may assert the Fifth Amendment privilege against self-incrimination. Any claim of Fifth Amendment privilege must be made in good faith. If you choose to assert the Fifth Amendment, you must do so in writing. You must fully respond to all other questions on the application. Your application for licensure or certification will be processed if you claim the Fifth Amendment privilege against self-incrimination. You should be aware, however, that you may later be directed by the Attorney General to answer a question that you have refused to answer on the basis of the Fifth Amendment, provided that the Attorney General first grants you immunity afforded by statutory law. (N.J.S.A. 45:1-20.)

"Ability to practice as an occupational therapist or occupational therapy assistant" is to be construed to include all of the following:

a. The cognitive capacity to exercise the reasonable judgments of an occupational therapist or occupational therapy assistant and to learn and keep abreast of professional developments; and

b. The ability to communicate those judgments and related information to clients and other interested parties, with or without the use of aids or devices, such as voice amplifiers; and

c. The physical capability to perform the duties of an occupational therapist or occupational therapy assistant, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, H.I.V. disease, tuberculosis, drug addiction and alcoholism.

"Chemical substance" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

"Currently" does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, or within the previous two years.

"Illegal use of controlled dangerous substance" means the use of a controlled dangerous substance obtained illegally (e.g. heroin or cocaine) as well as the use of controlled dangerous substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

a. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No

b. Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program**?

☐ Yes ☐ No ☐ Not applicable

c. Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or manner in which you have chosen to practice? ☐ Yes ☐ No ☐ Not applicable

d. Does your use of chemical substance(s) in any way impair or limit your ability to practice your profession with reasonable skill and safety? ☐ Yes ☐ No ☐ Not applicable

e. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?

☐ Yes ☐ No

f. Are you currently engaged in the illegal use of controlled dangerous substances? (Recall that "currently" is defined as "within the last two years.") ☐ Yes ☐ No

If you answered "Yes" to question f, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? ☐ Yes ☐ No

** If you receive such ongoing treatment or participate in such a monitoring program, the Council will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license or certificate should be issued, whether conditions should be imposed or whether you are not eligible for licensure or certification.

_____ _____

Applicant's signature Date

8. Have you ever changed your name? ☐ Yes ☐ No

   If "Yes," please submit with this application a copy of the marriage certificate, divorce decree or court order.

9. Have you ever been summoned; arrested; taken into custody; indicted; tried; charged with; admitted into pre-trial intervention (P.T.I.); or pled guilty to any violation of law, ordinance, felony, misdemeanor or disorderly persons offense, in New Jersey, any other state, the District of Columbia or in any other jurisdiction? (Paarking or speeding violations need not be disclosed, but motor vehicle violations such as driving while impaired or intoxicated must be.) ☐ Yes ☐ No

10. Have you ever been convicted of any crime or offense under any circumstances? This includes, but is not limited to, a plea of guilty, non vult, nolo contendere, no contest, or a finding of guilt by a judge or jury. ☐ Yes ☐ No

    If "Yes," provide a copy of the judgment of conviction and the release from parole or probation. Please provide a complete explanation. (Attach additional sheets of paper to this application.)

11. Do you currently hold, or have you ever held, a professional license or certificate of **any** kind in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

    If "Yes," for each license or certificate held, provide the date(s) held and the number(s). If the license or certificate was issued under a different name, please proivde that name.

_____
Last name First name Middle initial

Type of license or certificate	Number	State or jurisdiction that issued the license or certificate	Date issued/expired

Note: If you are licensed or certified as an occupational therapist in any other state, the District of Columbia or in any other jurisdiction, it is your responsibility to contact the licensing board in that jurisdiction to request that verification of your licensure or certiftion be sent directly to the Occupational Therapy Advisory Council.

12. Have you ever been disciplined or denied an occupational therapy or occupational therapy assistant's license or certificate or any other professional license or certificate in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

13. Have you ever had a professional license or certificate of any type suspended, revoked or surrendered in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

14. Has any action (including the assessment of fines or other penalties) ever been taken against your professional practice by any agency or certification board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

15. Have you ever been named as a defendant in any litigation related to the practice of occupational therapy or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

16. Are you aware of any investigation pending against a professional license or certificate issued to you by a professional board in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

17. Are there any criminal charges now pending against you in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

18. Have you ever been sanctioned by or is any action pending before any employer, association, society, or other professional group related to the practice of occupational therapy or other professional practice in New Jersey, any other state, the District of Columbia or in any other jurisdiction? ☐ Yes ☐ No

    If the answer to any of the above questions, numbers 12 through 18, is "Yes," provide a complete explanation of the circumstances leading to the action, and any supporting documentation, on separate sheets of paper.

Education

1. What is the name and address of the high school you attended?_____
   Name of high school

   _____
   Street address City State ZIP code

2. What years did you attend high school? _____

3. Did you graduate from high school? ☐ Yes ☐ No

   If "Yes," what was the date of your graduation?_____

   If "No," did you study to receive a G.E.D. certificate? ☐ Yes ☐ No

   If "Yes," please provide the name and address of the educational institution that issued your G.E.D. certificate and the date the certificate was issued.

   _____
   Name of educational institution

   _____
   Street address City State ZIP code

   Date certificate was issued: _____
   Month Day Year

4. List the colleges, universities or any other educational institutions you have attended, in chronological order.

   a. **Occupational therapists** - must show evidence of a Bachelor's Degree in Occupational Therapy, or a bachelor's degree in any other science plus a certificate in occupational therapy.

   b. **Occupational therapy assistants** - must show evidence of having successfully completed an associate's degree or its equivalent in occupational therapy, or an associate's degree in any other field plus a certificate in occupational therapy.

   c. **Internationally educated applicants** - must submit an official translation of their transcripts.

   Note: All degrees applicable to this application for a license as an occupational therapist or an occupational therapy assistant must be documented by an official transcript which must be sent directly from the institution to the Council.

   No action will be taken on your application until all transcripts have been received.

Month	Year		Month	Year	Name and address of institution	Degree and/or Certification
_____	_____	to	_____	_____	_____	_____
					_____	_____
					_____	_____
_____	_____	to	_____	_____	_____	_____
					_____	_____
					_____	_____
_____	_____	to	_____	_____	_____	_____
					_____	_____
					_____	_____

Month	Year	Month	Year	Name and address of institution	Degree and/or Certification
_____	_____	to _____	_____	_____	_____
				_____	_____
				_____	_____

Record of Professional Employment

List all professional activities in chronological order. Indicate the month and year when you began and ended each period of employment since graduation, starting with your present or last employer. In addition, provide an explanation for each period of unemployment. You should also provide the address of each facility where you performed your duties. (Attach additional sheets of paper if necessary.)

_____
Name of facility — Address

_____
Position — From (month/year) — To (month/year)

_____
Name of facility — Address

_____
Position — From (month/year) — To (month/year)

_____
Name of facility — Address

_____
Position — From (month/year) — To (month/year)

_____
Name of facility — Address

_____
Position — From (month/year) — To (month/year)

_____
Name of facility — Address

_____
Position — From (month/year) — To (month/year)

_____
Name of facility — Address

_____
Position — From (month/year) — To (month/year)

_____
Name of facility — Address

_____
Position — From (month/year) — To (month/year)

AFFIDAVIT

This affidavit is to be executed by the applicant before a notary public:

State of: _____

County of: _____ } ss.

I, _____, in making this application to the Occupational Therapy Advisory Council for licensure or certification under the provisions of Title 45 of the General Statutes of New Jersey and the Rules of the Occupational Therapy Advisory Council, swear (or affirm) that I am the applicant and that all information provided in connection with this application and any subsequent submissions is true to the best of my knowledge and belief. I understand that any omissions, inaccuracies or failure to make full disclosures may be deemed sufficient to deny licensure or certification or to withhold renewal of or suspend or revoke a certificate or license issued by the Council.

I further swear (or affirm) that I have read N.J.S.A. 45:9-37.51 et seq., together with the Rules and Regulations of the Occupational Therapy Advisory Council, N.J.A.C. 13:44K-1.1 et seq., and fully understand that in receiving licensure or certification from the Council, I bind myself to be governed by them.

Furthermore, I voluntarily consent to a thorough investigation of my present and past employment and other activities for the purpose of verifying my qualifications for licensure or certification. I further authorize all institutions, employers, agencies and all governmental agencies and instrumentalities (local, state, federal or foreign) to release any information, files or records requested by the Council.

_____
Applicant's signature

Sworn and subscribed to before me this _____

day of _____ ,_____
Month Year

_____
Name of notary public (please print)

_____
Signature of notary public

AFFIX
SEAL
HERE

Attach a clear, full-face passport-style photograph of your head and shoulders taken within the past six months.

A photo is required with each application.

Do not use staples to attach the photograph.

Polaroid or digital photographs are not acceptable.

NOTARY: AFFIX SEAL HERE

NOTARY STAMP Here

SIGNATURE OF APPLICANT John Doe

New Jersey Office of the Attorney General
Division of Consumer Affairs
Occupational Therapy Advisory Council
124 Halsey Street, 6th floor, P.O. Box 45037
Newark, New Jersey 07101
(973) 504-6570

For office use only

Application for Licensure

Date _____ Date of birth: _____

Check one: Check appropriate category

- ☐ Occupational Therapy
- ☐ Occupational Therapy Assistant

- ☐ License
- ☐ Temporary License

A nonrefundable application filing fee of $1[illegible] form of a check or money order made out to the State of New Jersey, must be submitted with this application for licensure or certification. (Applicants should understand that if the application filing fee is paid with a personal check, and the check is returned by the bank due to insufficient funds, the next step in the licensure or certification process will be delayed until the fee is paid.)

The Council maintains, as part of its responsibilities, a record of your home address, business address and mailing address. You may choose which of these addresses will be considered as your "address of record." If you do not indicate (by putting a check in the appropriate box) which address should be used as your address of record, your mailing address will be considered to be your address of record. A post office box may be used as your address of record, but only if you provide another address which includes a street, city, state and ZIP code.

Information that you provide on this application is subject to public disclosure as required by the Open Public Records Act (OPRA).

PHOTO PLACEMENT SAMPLE

Please print clearly. You must answer all of the questions on this application.

Personal Information

1. Name ☐ Mr. ☐ Mrs. ☐ Ms. _____ (_____)
   Last name | First name | Middle initial | Maiden name

2. Address

   ☐ Home: _____
   Street or P.O. Box | City | State | ZIP code | County

   _____ _____
   Telephone number (include area code) | E-mail address

   ☐ Business: _____
   Name of company | Telephone number (include area code)

   _____
   Street | City | State | ZIP code | County

   ☐ Mailing: _____
   Street or P.O. Box | City | State | ZIP code | County

New Jersey Office of the Attorney General
Division of Consumer Affairs
Occupational Therapy Advisory Council
124 Halsey Street, 6th Floor, P.O. Box 45037
Newark, NJ 07101
(973) 504-6570

Verification of State License

Section to be completed by the applicant.

To the applicant:

Complete this section of the form and mail the form to the licensing board in each state where you are now or ever have been licensed or certified to practice as an Occupational Therapist or Occupational Therapy Assistant. You may duplicate this form if necessary.

_____
Print or type the full name that appears on the license held.

_____ _____ _____
License number Date issued Date of birth

I hereby authorize the State of _____ to release all of the information in its files concerning my license or certificate and any actions or pending actions against my license or certificate to the New Jersey Occupational Therapy Advisory Council.

_____ _____
Signature Date

Section to be completed by the state in which the license is held.

_____ _____
Name of state verifying license Name of Occupational Therapist / Occupational Therapy Assistant

_____ _____ _____
License number Date issued Expiration date

Is the license or certification held by the above-named individual in good standing? (If "No," please attach the details and certified copies of any orders.) ☐ Yes ☐ No

To your knowledge, has this individual ever been disciplined by your board or any other regulatory agency? (If "Yes," please attach the details and certified copies of any orders.) ☐ Yes ☐ No

Is there presently or has there been in the past a disciplinary proceeding against this licensee? ☐ Yes ☐ No

_____
Name of applicant

If you have answered "Yes" to the above questions, please attach detailed information and certified copies of any orders. Please supply any additional comments or information that the Council should consider prior to determining this applicant's eligibility for licensure or certification.

_____

_____

_____ _____
Signature and title Date

Return the completed form to:

Occupational Therapy Advisory Council
P.O. Box 45037
Newark, NJ 07101

Please affix Board seal

New Jersey Office of the Attorney General
Division of Consumer Affairs
Occupational Therapy Advisory Council
124 Halsey Street, 6th Floor, Newark, NJ 07102

Occupational Therapy Advisory Council
Certificate of Good Moral Character

Section to be completed by applicant.

Please print clearly.

_____
Name of applicant

_____
Street address City State ZIP code

_____
Telephone number (include area code)

To the Occupational Therapy Advisory Council

Section to be completed by reference.

This to certify that _____, being known to me personally, is of good moral character. Therefore, I recommend this applicant for licensure as an Occupational Therapist/Occupational Therapy Assistant in the State of New Jersey pursuant to N.J.S.A. 45:9-37.51 et seq.

_____
Name of reference (excluding family members)

_____
Street address City State ZIP code

_____
Professional title Relationship to applicant

I hereby certify that the foregoing statements made by me are true. I am aware that if the foregoing statements made by me are willfully false, I am subject to punishment.

_____ _____
Signature (referene) Date

JON S. CORZINE
Governor

New Jersey Office of the Attorney General

Division of Consumer Affairs
Occupational Therapy Advisory Council
124 Halsey Street, 6th Floor, Newark, NJ 07102

ZULIMA V. FARBER
Attorney General

STEPHEN B. NOLAN
Acting Director

Mailing Address:
P.O. Box 45037
Newark, NJ 07101
(973) 504-6570

Initial Verification of Supervision

(FOR TEMPORARY LICENSE APPLICANTS ONLY)

Circle one: OT OTA

Pursuant to N.J.S.A. 45:9-37.67 a temporary licensee may practice Occupational Therapy in New Jersey ***only under the direct supervision*** of a licensed occupational therapist.

This ***initial form*** is to be submitted ***before employment begins*** and returned to the above mailing address along with a certified check or money order in the amount of $ 50.00 payable to the Occupational Therapy Advisory Council.

Whenever a change of supervision occurs a new form must be completed and immediately filed with the Advisory Council at the above mailing address. When supervision has been completed a ***final supervision form*** must be filed with the Council at the above mailing address.

It is the responsibility of the supervising Occupational Therapist (s) at each place of employment to complete and file ***initial*** and ***final*** forms with the Council.

_____ will be performing his/her professional activities
name of applicant (please print)

under the direct supervision of the following New Jersey Licensed Occupational Therapist.

_____
Occupational Therapist name (please print) *permanent license number*

Name of Facility _____
(please print)

Address _____
(please print)

_____
city *state* *Zip code* *telephone number*

Starting date of Supervision _____

NOTE: *Any person practicing Occupational Therapy in the State of New Jersey* ***after*** *July 1, 2001 must be licensed pursuant to N.J.S.A. 45:9-37.52 et.seq.*

_____
signature of licensed O.T. supervisor

I:\OTLicensure\OTApplications\InitialVerif.TempLic.rev 03.2006

JON S. CORZINE
Governor

New Jersey Office of the Attorney General

Division of Consumer Affairs
Occupational Therapy Advisory Council
124 Halsey Street, 6th Floor, Newark, NJ 07102

ZULIMA V. FARBER
Attorney General

STEPHEN B. NOLAN
Acting Director

Mailing Address:
P.O. Box 45037
Newark, NJ 07101
(973) 504-6570

Final Verification of Supervision Form

(For Temporary License Applicants Only)

Circle one: OT OTA

Pursuant to N.J.S.A. 45:9-37.67 a temporary licensee may practice Occupational Therapy in New Jersey ***only under the direct supervision*** of a licensed occupational therapist

This ***final supervision form*** is to be submitted to the Council when ***employment ends***. Whenever a change of supervision occurs a new form must be completed and immediately filed with the Advisory Council at the above mailing address. When supervision has been completed a ***final supervision form*** must be filed with the Council at the above mailing address.

It is the responsibility of the supervising Occupational Therapists(s) at each place of employment to complete and file ***initial*** and ***final*** supervision forms with the Council.

_____ was performing his/her professional activities
name of applicant (please print)

under the direct supervision of the following N.J. Permanent licensed Occupational Therapist.

_____
Occupational Therapist name (please print) permanent license number

Name of Facility _____
(please print)

Address _____
(please print)

City _____ State _____ Zip Code_____ Telephone No_____

Date Supervision ended _____

Reason:_____

NOTE: *Any person practicing Occupational Therapy after July 1, 2001 must be licensed pursuant to N.J.S.A. 45:9-37.52 et.seq.*

_____
Signature of licensed O.T. supervisor